Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS649HOS	A. BUILDING _____ B. WING _____	12/01/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH VISTA HOSPITAL	1409 EAST LAKE MEAD BLVD NORTH LAS VEGAS, NV 89030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments This Statement of Deficiencies was generated as a result of complaint investigation conducted in your facility on 12/1/10 and finalized on 12/1/10, in accordance with Nevada Administrative Code, Chapter 449, Hospital. Complaint #NV00026936 was unsubstantiated. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. No regulatory deficiencies were identified. The complaint investigative process was initiated by the Bureau of Health Care Quality and Compliance on 12/1/10. The investigation for the allegation of Resident/Patient/Client Abuse: Physical included: Review of the medical record. The medical record did not provide evidence of an injury occuring to the patient's left side. Interviews were conducted with the Chief Nursing Officer, The Director of Radiology, The Director of Quiality Assurance and the nurse who cared for the patient.	S 000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE